



## Senate

General Assembly

**File No. 242**

February Session, 2010

Substitute Senate Bill No. 194

*Senate, April 1, 2010*

The Committee on Insurance and Real Estate reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

### **AN ACT CONCERNING RATE APPROVALS FOR CERTAIN HEALTH INSURANCE POLICIES.**

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Subsections (a) to (c), inclusive, of section 38a-481 of the  
2 2010 supplement to the general statutes are repealed and the following  
3 is substituted in lieu thereof (*Effective July 1, 2010*):

4 (a) (1) No individual health insurance policy shall be delivered or  
5 issued for delivery to any person in this state, nor shall any  
6 application, rider or endorsement be used in connection with such  
7 policy, until a copy of the form thereof and of the classification of risks  
8 and the premium rates have been filed with the commissioner. The  
9 commissioner shall adopt regulations, in accordance with chapter 54,  
10 to establish a procedure for reviewing such policies. The commissioner  
11 shall disapprove the use of such form at any time if it does not comply  
12 with the requirements of law, or if it contains a provision or provisions  
13 [which] that are unfair or deceptive or [which] that encourage  
14 misrepresentation of the policy. The commissioner or the

15 commissioner's designee shall notify, in writing, the insurer [which]  
16 that has filed any such form of the commissioner's disapproval,  
17 specifying the reasons for disapproval, and [ordering] communicating  
18 that no such insurer shall deliver or issue for delivery to any person in  
19 this state a policy on or containing such form. The provisions of section  
20 38a-19 shall apply to such [orders] notifications of disapprovals.

21 (2) The commissioner may prescribe requirements for disclosure  
22 notices, illustrations or other explanatory materials said commissioner  
23 deems necessary to protect policyholders.

24 (b) No rate filed under the provisions of subsection (a) of this  
25 section shall be effective [until the expiration of thirty days after it has  
26 been filed or] unless [sooner] approved by the commissioner [in  
27 accordance with regulations adopted pursuant to this subsection] as  
28 set forth in section 2 of this act. The commissioner shall adopt  
29 regulations, in accordance with chapter 54, to prescribe standards to  
30 [insure] ensure that such rates shall not be excessive, inadequate or  
31 unfairly discriminatory, as defined in section 2 of this act. [The  
32 commissioner may disapprove such rate within thirty days after it has  
33 been filed if it fails to comply with such standards, except that no rate  
34 filed under the provisions of subsection (a) of this section for any  
35 Medicare supplement policy shall be effective unless approved in  
36 accordance with section 38a-474.]

37 (c) (1) No rate filed under the provisions of subsection (a) of this  
38 section for a Medicare supplement policy shall be effective unless  
39 approved in accordance with section 38a-474.

40 (2) No insurance company, fraternal benefit society, hospital service  
41 corporation, medical service corporation, health care center or other  
42 entity [which] that delivers or issues for delivery in this state any  
43 Medicare supplement policies or certificates shall incorporate in its  
44 rates or determinations to grant coverage for Medicare supplement  
45 insurance policies or certificates any factors or values based on the age,  
46 gender, previous claims history or the medical condition of any person  
47 covered by such policy or certificate. [, except for plans "H" to "J",

48 inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive,  
49 previous claims history and the medical condition of the applicant may  
50 be used in determinations to grant coverage under Medicare  
51 supplement policies and certificates issued prior to January 1, 2006.]

52 Sec. 2. (NEW) (*Effective July 1, 2010*) (a) (1) Any (A) rate filing made  
53 pursuant to section 38a-481 of the general statutes, as amended by this  
54 act, (B) schedule of amounts filed pursuant to section 38a-183 of the  
55 general statutes, as amended by this act, (C) schedule of rates filed  
56 pursuant to section 38a-208 of the general statutes, as amended by this  
57 act, or (D) schedule of rates filed pursuant to section 38a-218 of the  
58 general statutes, as amended by this act, on or after July 1, 2010, shall  
59 be filed not later than one hundred twenty calendar days prior to the  
60 proposed effective date of such rates or amounts.

61 (2) Each filer making a rate or amount filing pursuant to this  
62 subsection shall:

63 (A) On the date the filer submits such rate or amount filing to the  
64 Insurance Commissioner, clearly and conspicuously disclose to its  
65 insureds or subscribers, in writing and in such form as the  
66 commissioner may prescribe: (i) The proposed general rate or amount  
67 increase and the dollar amount by which an insured's or subscriber's  
68 policy or agreement will increase, including any increase because of  
69 the insured's or subscriber's age or change in age rating classification  
70 and the percentage increase or decrease of the proposed rate or  
71 amount from the current rate or amount; (ii) a statement that the  
72 proposed rate or amount is subject to Insurance Department review  
73 and approval; and (iii) information on the insured's right to submit  
74 public comment as set forth in this section; and

75 (B) Include with its rate or amount filing an actuarial memorandum,  
76 certified by a qualified actuary, as defined in section 38a-78 of the  
77 general statutes, that to the best of such actuary's knowledge, (i) such  
78 rate or amount filing is in compliance with law, and (ii) the rate or  
79 amount filing is not excessive, as defined in this section.

80 (3) (A) Notwithstanding section 38a-69a of the general statutes, the  
81 Insurance Department shall post on its Internet web site all documents,  
82 materials and other information provided to or requested by the  
83 department in relation to a rate or amount filing made pursuant to this  
84 subsection, including, but not limited to, financial reports, financial  
85 statements, actuarial reports and actuarial memoranda. The rate or  
86 amount filing and the documents, materials and other information  
87 shall be posted not later than three business days after the department  
88 receives such filing, and such posting shall be updated to include any  
89 correspondence between the department and the filer.

90 (B) The department shall provide for a written public comment  
91 period of thirty days following the posting of such filing. The  
92 department shall include in such posting the date the public comment  
93 period closes and instructions on how to submit comments to the  
94 department.

95 (4) Except where a hearing is required under subsection (b) of this  
96 section, the commissioner shall issue a written decision approving,  
97 disapproving or modifying a rate or amount filing not later than forty-  
98 five days after such filing was made. Such decision shall specify all  
99 factors used to reach such decision and shall be posted on the Internet  
100 web site of the Insurance Department not later than two business days  
101 after the commissioner issues such decision.

102 (5) The commissioner shall not approve a rate or amount filing  
103 made under this section if it is excessive, inadequate or unfairly  
104 discriminatory.

105 (A) A rate or amount is excessive if it is unreasonably high for the  
106 insurance provided in relation to the underlying risks and costs.

107 (B) A rate or amount is inadequate if it is unreasonably low for the  
108 insurance provided in relation to the underlying risks and costs and  
109 continued use of such rate or amount would endanger solvency of the  
110 filer.

111 (C) A rate or amount is unfairly discriminatory if the premium  
112 charged for any classification is not reasonably related to the  
113 underlying risks and costs, such that different premiums result for  
114 insureds with similar risks and costs.

115 (6) In reviewing a rate or amount filing to determine if such filing is  
116 not excessive, inadequate or unfairly discriminatory and is therefore  
117 reasonable, the commissioner shall:

118 (A) Conduct an actuarial review to determine if the methodology  
119 and assumptions used to develop the rate or amount filing are  
120 actuarially sound and in compliance with the Actuarial Standards of  
121 Practice issued by the Actuarial Standards Board; and

122 (B) Give due consideration to (i) the experience of the filer, (ii) the  
123 past and projected costs of the filer including amounts paid and to be  
124 paid for commissions, (iii) any transfers of funds to the holding or  
125 parent company, subsidiary or affiliate of the filer, (iv) the filer's rate of  
126 return on assets or profitability, as compared to similar filers, (v) a  
127 reasonable margin for profit and contingencies, (vi) any public  
128 comments received on such filing, and (vii) other factors the  
129 commissioner deems relevant.

130 (b) (1) If (A) a rate filing made pursuant to section 38a-481 of the  
131 general statutes, as amended by this act, for health insurance that  
132 provides coverage of the type specified in subdivisions (1), (2), (4), (11)  
133 and (12) of section 38a-469 of the general statutes, (B) a schedule of  
134 amounts filed pursuant to section 38a-183 of the general statutes, as  
135 amended by this act, (C) a schedule of rates filed pursuant to section  
136 38a-208 of the general statutes, as amended by this act, or (D) a  
137 schedule of rates filed pursuant to section 38a-218 of the general  
138 statutes, as amended by this act, is for more than a ten per cent  
139 increase in such rate or amount and upon request of the Healthcare  
140 Advocate or the Attorney General not later than five business days  
141 after such rate or amount filing has been posted on the Internet web  
142 site of the Insurance Department, the commissioner shall, not later  
143 than five business days after the receipt of such request, set a hearing

144 date on such rate or amount filing and post the date, place and time of  
145 the hearing in a conspicuous place on the Internet web site of the  
146 department.

147 (2) Such hearing shall be (A) held not later than ninety calendar  
148 days prior to the proposed effective date of such rate or amount, at a  
149 place and time that is convenient to the public, and (B) conducted in  
150 accordance with chapter 54 of the general statutes, this section and  
151 section 3 of this act.

152 (3) Upon setting the date, place and time of the hearing on the  
153 proposed rate or amount, the commissioner shall immediately notify  
154 the filer of the date, place and time of the hearing.

155 (c) Not later than thirty calendar days after the hearing, the  
156 commissioner shall issue a written decision approving, disapproving  
157 or modifying the rate or amount filing. Such decision shall specify all  
158 factors used to reach such decision and shall be posted on the Internet  
159 web site of the Insurance Department not later than two business days  
160 after the commissioner issues such decision.

161 (d) Each insurance company, health care center, hospital service  
162 corporation or medical service corporation subject to the provisions of  
163 this section shall disclose in writing to a prospective customer of a  
164 policy or agreement that may be affected by a rate or amount filing  
165 made pursuant to this section, (1) that the rate or amount of such  
166 policy or agreement is under review by the Insurance Department, and  
167 (2) the proposed increase or decrease in the rate or amount of such  
168 policy or agreement.

169 (e) Each insurance company, health care center, hospital service  
170 corporation or medical service corporation subject to the provisions of  
171 this section shall retain records of all earned premiums and incurred  
172 benefits per calendar year for each policy or agreement for which a  
173 rate or amount filing is made pursuant to section 2 of this act. Such  
174 records shall be retained for not less than seven years after the date  
175 each such filing is made and shall include records for any rider or

176 endorsement used in connection with such policy or agreement.

177       Sec. 3. (NEW) (*Effective July 1, 2010*) (a) Notwithstanding sections 4-  
178 176 and 4-177a of the general statutes, the Healthcare Advocate or the  
179 Attorney General, or both, may be parties to any hearing held  
180 pursuant to section 2 of this act.

181       (b) Subject to the provisions of section 4-181 of the general statutes,  
182 (1) the Healthcare Advocate or the Attorney General, or both, shall  
183 have access to the records of the Insurance Department regarding a  
184 rate or amount filing made pursuant to section 2 of this act, and (2)  
185 attorneys, actuaries, accountants and other experts who are part of the  
186 Insurance Commissioner's staff and who review or assist in the  
187 determination of such filing shall cooperate with the Healthcare  
188 Advocate or Attorney General, or both, to carry out the provisions of  
189 this section.

190       (c) The Healthcare Advocate or the Attorney General, or both, may  
191 (1) summon and examine under oath, such witnesses as the Healthcare  
192 Advocate or the Attorney General deems necessary to the review of a  
193 rate or amount filing made pursuant to section 2 of this act, and (2)  
194 require the filer or any holding or parent company or subsidiary of  
195 such filer to produce books, vouchers, memoranda, papers, letters,  
196 contracts and other documents, regardless of the format in which such  
197 materials are stored. Such books, vouchers, memoranda, papers,  
198 letters, contracts and other documents shall be limited to such  
199 information or transactions between the filer and the holding or parent  
200 company or subsidiary that are reasonably related to the subject matter  
201 of the filing.

202       Sec. 4. (NEW) (*Effective July 1, 2010*) (a) If the Insurance  
203 Commissioner issues a decision to approve or modify a rate or amount  
204 filing made pursuant to section 2 of this act, the filer shall provide  
205 written notice to each insured or subscriber by first class mail that  
206 states (1) the approved rate or amount for the insured's or subscriber's  
207 policy or agreement, (2) any increase in the rate or amount due to the  
208 insured's or subscriber's age or change in age rating classification, and

209 (3) the percentage increase or decrease of the approved rate from the  
210 current rate of the insured or subscriber.

211 (b) No such rate or amount shall be effective until thirty calendar  
212 days after the notice has been sent by the filer as set forth in subsection  
213 (a) of this section.

214 Sec. 5. Subsection (a) of section 38a-183 of the general statutes is  
215 repealed and the following is substituted in lieu thereof (*Effective July*  
216 *1, 2010*):

217 (a) A health care center governed by sections 38a-175 to 38a-192,  
218 inclusive, shall not enter into any agreement with subscribers unless  
219 and until it has filed with the commissioner a full schedule of the  
220 amounts to be paid by the subscribers and has obtained the  
221 commissioner's approval [thereof] as set forth in section 2 of this act.  
222 [The commissioner may refuse such approval if he finds such amounts  
223 to be excessive, inadequate or discriminatory.] Each such health care  
224 center shall not enter into any agreement with subscribers unless and  
225 until it has filed with the commissioner a copy of such agreement or  
226 agreements, including all riders and endorsements thereon, and until  
227 the commissioner's approval thereof has been obtained. [The  
228 commissioner shall, within a reasonable time after the filing of any  
229 request for an approval of the amounts to be paid, any agreement or  
230 any form, notify the health care center of either his approval or  
231 disapproval thereof.]

232 Sec. 6. Section 38a-208 of the general statutes is repealed and the  
233 following is substituted in lieu thereof (*Effective July 1, 2010*):

234 No such corporation shall enter into any contract with subscribers  
235 unless and until it has filed with the Insurance Commissioner a full  
236 schedule of the rates to be paid by the subscribers and has obtained  
237 said commissioner's approval [thereof] as set forth in section 2 of this  
238 act. [The commissioner may refuse such approval if he finds such rates  
239 to be excessive, inadequate or discriminatory.] No hospital service  
240 corporation shall enter into any contract with subscribers unless and

241 until it has filed with the Insurance Commissioner a copy of such  
242 contract, including all riders and endorsements thereof, and until said  
243 commissioner's approval thereof has been obtained. [The Insurance  
244 Commissioner shall, within a reasonable time after the filing of any  
245 such form, notify such corporation either of his approval or  
246 disapproval thereof.]

247 Sec. 7. Section 38a-218 of the general statutes is repealed and the  
248 following is substituted in lieu thereof (*Effective July 1, 2010*):

249 No such medical service corporation shall enter into any contract  
250 with subscribers unless and until it has filed with the Insurance  
251 Commissioner a full schedule of the rates to be paid by the subscriber  
252 and has obtained said commissioner's approval [thereof] as set forth in  
253 section 2 of this act. [The commissioner may refuse such approval if he  
254 finds such rates are excessive, inadequate or discriminatory.] No such  
255 medical service corporation shall enter into any contract with  
256 subscribers unless and until it has filed with the Insurance  
257 Commissioner a copy of such contract, including all riders and  
258 endorsements thereof, and until said commissioner's approval thereof  
259 has been obtained. [The Insurance Commissioner shall, within a  
260 reasonable time after the filing of any such form, notify such  
261 corporation either of his approval or disapproval thereof.]

262 Sec. 8. Section 11-8a of the general statutes is repealed and the  
263 following is substituted in lieu thereof (*Effective July 1, 2010*):

264 (a) The State Librarian shall, in the performance of his duties  
265 pursuant to section 11-8, consult with the Attorney General, the  
266 Probate Court Administrator and the chief executive officers of the  
267 Connecticut Town Clerks Association and the Municipal Finance  
268 Officers Association of Connecticut, or their duly appointed  
269 representatives.

270 (b) The State Librarian may require each such state agency, or each  
271 political subdivision of the state, including each probate district, to  
272 inventory all books, records, papers and documents under its

273 jurisdiction and to submit to him for approval retention schedules for  
274 all such books, records, papers and documents, or he may undertake  
275 such inventories and establish such retention schedules, based on the  
276 administrative need of retaining such books, records, papers and  
277 documents within agency offices or in suitable records centers. Each  
278 agency head, and each local official concerned, shall notify the State  
279 Librarian of any changes in the administrative requirements for the  
280 retention of any book, record, paper or document subsequent to the  
281 approval of retention schedules by the State Librarian.

282 (c) If the Public Records Administrator and the State Archivist  
283 determine that certain books, records, papers and documents which  
284 have no further administrative, fiscal or legal usefulness are of  
285 historical value to the state, the State Librarian shall direct that they be  
286 transferred to the State Library. If the State Librarian determines that  
287 such books, records, papers and documents are of no administrative,  
288 fiscal, or legal value, and the Public Records Administrator and State  
289 Archivist determine that they are of no historical value to the state, the  
290 State Librarian shall approve their disposal, whereupon the head of the  
291 state agency or political subdivision shall dispose of them as directed  
292 by the State Librarian.

293 (d) The State Librarian may establish and carry out a program of  
294 inventorying, repairing and microcopying for the security of those  
295 records of political subdivisions of the state which he determines to  
296 have permanent value; and he may provide safe storage for the  
297 security of such microcopies of such records.

298 (e) The State Library Board may transfer any of the books, records,  
299 documents, papers, files and reports turned over to the State Librarian  
300 pursuant to the provisions of this section and section 11-4c. The State  
301 Library Board shall have sole authority to authorize any such transfers.  
302 The State Library Board shall adopt regulations pursuant to chapter 54  
303 to carry out the provisions of this subsection.

304 (f) Each state agency shall cooperate with the State Librarian to  
305 carry out the provisions of this section and shall designate an agency

306 employee to serve as the records management liaison officer for this  
 307 purpose.

308 (g) Notwithstanding subsections (b) and (c) of this section, the  
 309 Insurance Department shall retain all records of any rate or amount  
 310 filing made pursuant to section 2 of this act for not less than seven  
 311 years after the date such filing was approved, disapproved or  
 312 modified.

This act shall take effect as follows and shall amend the following sections:		
Section 1	<i>July 1, 2010</i>	38a-481(a) to (c)
Sec. 2	<i>July 1, 2010</i>	New section
Sec. 3	<i>July 1, 2010</i>	New section
Sec. 4	<i>July 1, 2010</i>	New section
Sec. 5	<i>July 1, 2010</i>	38a-183(a)
Sec. 6	<i>July 1, 2010</i>	38a-208
Sec. 7	<i>July 1, 2010</i>	38a-218
Sec. 8	<i>July 1, 2010</i>	11-8a

**Statement of Legislative Commissioners:**

In section 2(a) (5)(C), "filers" was changed to "insureds" for accuracy.

**INS**      *Joint Favorable Subst.*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

### **OFA Fiscal Note**

#### **State Impact:**

Agency Affected	Fund-Effect	FY 11 \$	FY 12 \$
Insurance Dept.	IF - Cost	387,500	387,500

Note: IF=Insurance Fund

**Municipal Impact:** None

#### **Explanation**

The bill would result in a cost to the Department of Insurance (DOI) of \$387,500 in both FY 11 and FY 12 to implement new rate filing procedures, which include requiring public hearings for filed rate increases of more than 10%. It is estimated that there would be 31 rate filings<sup>1</sup> that would meet this threshold annually. These hearings would require outside actuarial hearing officers to review the filing, operate the hearing, and prepare and submit documents (including public comments) at the cost of approximately \$500 an hour. Assuming twenty hours of work per hearing, the total cost for a hearing officer would be \$10,000 per hearing. Transcriber costs would also be incurred at \$2,500 per hearing. Costs are detailed below:

Item	FY 11 \$	FY 12 \$
Hearing Officers	310,000	310,000
Transcriber	77,500	77,500
<b>TOTAL</b>	<b>387,500</b>	<b>387,500</b>

#### **The Out Years**

The annualized ongoing fiscal impact identified above would

<sup>1</sup> Based on the number of actual filings for subdivisions (1), (2), (4), (11) and (12) CGS 38a-469 in 2009 that exceeded the 10% trigger, as reported by DOI.

continue into the future subject to the number of rate increases filed with DOI that meet the threshold of a greater than 10% rate increase.

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**OLR Bill Analysis****sSB 194*****AN ACT CONCERNING RATE APPROVALS FOR CERTAIN HEALTH INSURANCE POLICIES.*****SUMMARY:**

This bill establishes a new rate approval process for individual health insurance companies, HMOs, and hospital and medical service corporations. The bill:

1. increases the amount of time required before a new rate can go into effect,
2. requires the Insurance Department to post rate filings on its website and provide a 30-day public comment period,
3. requires a public hearing to be held on a proposed rate filing if it would increase rates by more than 10% and the healthcare advocate or attorney general requests the hearing within a specified time period,
4. allows the healthcare advocate and attorney general to be parties to such a hearing, and
5. establishes disclosure and record retention requirements for rate filings.

The bill also makes minor, technical, and conforming changes.

EFFECTIVE DATE: July 1, 2010

**RATE APPROVAL PROCESS**

Current law requires individual health insurers, HMOs, and hospital and medical service corporations to file proposed premium

rates with the insurance commissioner for review and approval. Rates may not be excessive, inadequate, or unfairly discriminatory. For individual health insurance, rates are deemed approved if not otherwise disapproved within 30 days of being filed with the department. For HMOs and hospital and medical service corporations, the commissioner has to approve or disapprove rates within a reasonable time.

The bill instead requires the entities to file rates with the department within 120 days before their proposed effective date. The department must post the filing and supporting documents on its website within three business days of receiving it and update the file to include any correspondence between the department and the entity that filed it.

The department must provide for a 30-day public comment period once the filing is posted on the website. The website posting must include the day the public comment period ends and how to submit written comments to the department.

Unless a hearing is required on the filing (see below), the commissioner must issue a written decision approving, modifying, or disapproving a rate filing within 45 days after receiving the filing. The decision must specify all factors used to reach it and be posted on the department's website within two business days from being issued.

### ***Disclosure to Insureds or Subscribers***

The bill requires each entity to disclose to its insureds or subscribers, on the date it submits a rate filing to the department, clearly and conspicuously, in writing, and in a form the commissioner prescribes:

1. the proposed general rate increase and the dollar amount by which a person's policy or agreement will increase, including any increase because of the person's age or change in age rating classification and the percentage increase or decrease of the proposed rate from the current rate;

2. a statement that the proposed rate or amount is subject to department review and approval; and
3. information on the person's right to submit public comment.

The entity must disclose in writing to a prospective customer the (1) fact that the department is reviewing the policy rates and (2) proposed rate increase or decrease.

If the insurance commissioner approves or modifies a rate filing, the entity must provide written notice to each insured or subscriber by first class mail that states:

1. the approved rate for the person's policy or agreement,
2. any increase in the rate due to the person's age or change in age rating classification, and
3. the percentage increase or decrease of the approved rate from the person's current rate.

The bill prohibits a new rate from taking effect until 30 days after the notice has been sent.

### ***Actuarial Memorandum***

The entity's rate filing must include an actuarial memorandum certified by a qualified actuary (i.e., a member in good standing with the American Academy of Actuaries who meets requirements set forth in regulations that the commissioner may prescribe). The actuary must certify that, to the best of his or her knowledge, the rate filing complies with law and is not excessive.

### ***Excessive, Inadequate, Unfairly Discriminatory***

By law, rates may not be excessive, inadequate, or unfairly discriminatory. The bill defines these terms.

A rate is "excessive" if it is unreasonably high for the insurance in relation to the underlying risks and costs. It is "inadequate" if it is

unreasonably low in relation to the underlying risks and costs and continued use of the rate would endanger the filer's solvency. A rate is "unfairly discriminatory" if the premium charged for any classification is not reasonably related to the underlying risks and costs, such that different premiums result for insureds with similar risks and costs.

***Rate Filing Review Requirements***

The bill requires the insurance commissioner, when reviewing a rate filing to determine that it is not excessive, inadequate, or unfairly discriminatory, to conduct his own actuarial review to determine if the methodology and assumptions used to develop the rate filing are actuarially sound and comply with the Actuarial Standards of Practice issued by the Actuarial Standards Board. The commissioner must also give due consideration to:

1. the filer's experience;
2. the filer's past and projected costs, including amounts paid and to be paid for commissions;
3. any transfers of funds to the filer's holding or parent company, subsidiary, or affiliate;
4. the filer's rate of return on assets or profitability, as compared to similar filers,
5. a reasonable margin for profit and contingencies,
6. any public comments received related to the filing, and
7. other factors the commissioner deems relevant.

***Public Hearing Required for Certain Rate Filings***

Under the bill, the commissioner must hold a public hearing on certain rate filings. A hearing must be held if:

1. the rate filing is from an HMO, hospital or medical service corporation, or an individual health insurer that issues policies

that cover (a) basic hospital expenses; (b) basic medical-surgical expenses; (c) major medical expenses; and (d) hospital or medical services;

2. the rate filing is for more than a 10% increase; and
3. the healthcare advocate or attorney general requests a hearing within five business days of when the department posts the filing on its website.

If these criteria are met, the commissioner must, within five days from the healthcare advocate's or attorney general's request, set a hearing date and conspicuously post on the department's website the date, place, and time of the hearing. The bill requires the hearing to be held (1) within 90 days before the proposed effective date of the rate filing at a place and time convenient for the public and (2) in accordance with law. The commissioner must immediately notify the filer of the hearing date, place, and time.

The commissioner must, within 30 days after the hearing, issue a written decision approving, modifying, or disapproving the rate filing. The decision must specify all factors used to reach it and be posted on the department's website within two business days from being issued.

### ***Healthcare Advocate and Attorney General***

The bill authorizes the healthcare advocate, the attorney general, or both, to be a party to any rate filing hearing held.

It grants these officials access to the department's rate filing records. Department attorneys, actuaries, accountants, and other experts who review or assist in the determination of a rate filing must cooperate with the officials.

The officials may (1) summon and examine under oath witnesses either deems necessary to the rate filing review and (2) require the filer, or any holding or parent company or subsidiary, to produce books, vouchers, memoranda, papers, letters, contracts, and other

documents. Such material must be limited to information or transactions between the filer and the holding or parent company or subsidiary that are reasonably related to the filing.

***Record Retention***

The bill requires each insurer, HMO, or hospital or medical service corporation to retain records of earned premiums and incurred benefits by calendar year for each policy or agreement for which a rate filing was made under the bill. The records must be kept for at least seven years after the filing was made and must include records for any rider or endorsement used in connection with the policy or agreement.

The bill requires the Insurance Department to retain rate filing records for at least seven years from when the department approved, modified, or disapproved the filing.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable Substitute

Yea 14 Nay 5 (03/16/2010)